STATE OF MISSOURI
DEPARTMENT OF INSURANCE
MARKET CONDUCT
PROVIDER COMPLAINT FORM/RELATED TO PROMPT PAYMENT OF HEALTH CLAIMS

INSTRUCTIONS

PLEASE COMPLETE ALL ITEMS BELOW AND ENCLOSE COPIES OF ANY CORRESPONDENCE OR OTHER PAPERS WHICH YOU FEEL WOULD HELP THE INVESTIGATION OF YOUR COMPLAINT. SIGN AND DATE AT THE BOTTOM. **A COPY OF THIS FORM AND ANY OR ALL OF THE ENCLOSED INFORMATION MAY BE SENT TO THE PARTY COMPLAINED AGAINST.** SEND COMPLETED FORM ALONG WITH ANY ATTACHMENTS TO

MISSOURI DEPARTMENT OF INSURANCE
MARKET CONDUCT SECTION
P.O. BOX 690
JEFFERSON CITY MO 65102-0690
(573)-751-2425
(800)-726-7390
(573)-526-4536 TDD

PLEASE PRINT, TYPE OR WRITE CLEARLY IN BLACK OR BLUE INK

1. Name of Provider		
Tax ID Number		
Complete Mailing Address		
Telephone Number		
2. Name of Insured		
Complete Mailing Address		
3. Who is Complaint Against (Name of TPA or HMO)		
Complete Mailing Address		
Group #	**Policy #**	**Date of Issue**
ID #	**Certificate #**	**Date of Issue**
Claim #	**Date of Loss**	
Type of Coverage ☐ **Individual Health** ☐ **Group Health** ☐ **Med Supplement** ☐ **Other**		
Details of Complaint		
SIGNATURE OF COMPLAINTANT		
DATE		